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Annual Oration

What is Beauty?

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INTRODUCTION

Let me start with Confucius who said "everything has its beauty but not everyone sees it". Beauty is... We all remember sayings such as beauty is skin deep, is only skin deep, is not only skin deep, is in the eye of the beholder, comes from within and so forth. The American writer Jean Kerr said "I'm tired of all this nonsense about beauty being only skin deep. That's deep enough. What do you want - an adorable pancreas?" And for those of you who believe in the new saying that beauty is in a jab and have come to hear about Botox, peels and fillers, they will not get a mention, so do leave now if you wish. But before you go, let me draw your attention to a poem of Thomas Campion a Renaissance English poet, of whom it was said "he had the generous illusions of youth; devoted to the studies of poetry, music, and medicine, clothed with that finer tact and sympathy which comes to a good physician", surely still applicable to today's students, but in his poem he said:

"Beauty is but a painted hell;
shee wounds them that admire it,
shee kils them that desire it.
Give her pride but fuell,
no fire is more cruell."

But beauty is not just a visual experience; it is a characteristic that provides a perceptual experience to the eye, the ear, the intellect, the aesthetic faculty, or the moral sense. It is the qualities that give pleasure, meaning or satisfaction to the senses, but in this talk I wish to concentrate on the eye, the intellect and the moral sense.

It was the late CP Snow, a true polymath, who gave the Rede lecture in 1959 and subsequently wrote a book, both under the title The Two Cultures, in which he bemoaned the split that had taken place between the scientists and the literary intellectuals. In education, when I was at school and to a large degree it remains, even today, there is a division as to whether one follows a scientific or an arts direction, to the detriment of the other. His theory was boosted when the critic FR Leavis published his attack on the Two Cultures. He wrote of Snow's "complete ignorance of history, literature and the history of civilization… his incapacity as a novelist is … total… not only is he not a genius he is intellectually as undistinguished as it is possible to be." For those of you who have come expecting a little gentle admonition, I am afraid you are going to be either relieved or disappointed; as there is no way that I could match that. But it is one of history's ironies that nearly eighty years earlier, Matthew Arnold in giving the same lecture had made the opposite point. Written in response to an argument that literature should and inevitably would be supplanted by science, he argued, "so long as human nature is what it is, culture would continue to provide mankind with its fulcrum of moral understanding". I would suggest that there is still a role for science and art in modern medicine and I wish to show that they should be interlinked in the training for and practice of medicine.

BEAUTY

So what is beauty? First let me perhaps surprise you by stating that beauty can be defined numerically:- 1.6180339887. That is beauty - that is the golden ratio (fig 1). It was described by the Pythagorean mathematicians, as they kept seeing this ratio in things regarded as beautiful, and it was first written down by Euclid, and can be expressed either as a linear relationship or as a shape, in either case the ratio is (a+b) is to a as a is to b and is behind the pattern of many shapes we find pleasing, be it architecture, form, people - all tend to this ratio when regarded as beautiful, and with that ratio we also expect to find balance and symmetry. The Parthenon has these ratios, and balance. People also and if we look at those regarded today as beautiful, then again the ratio applies, as does symmetry, both to the face and body. The head forms a golden rectangle and the mouth and nose are placed at golden sections of the distance between the eyes and the chin, and there are many others present and when we look at the human body then the

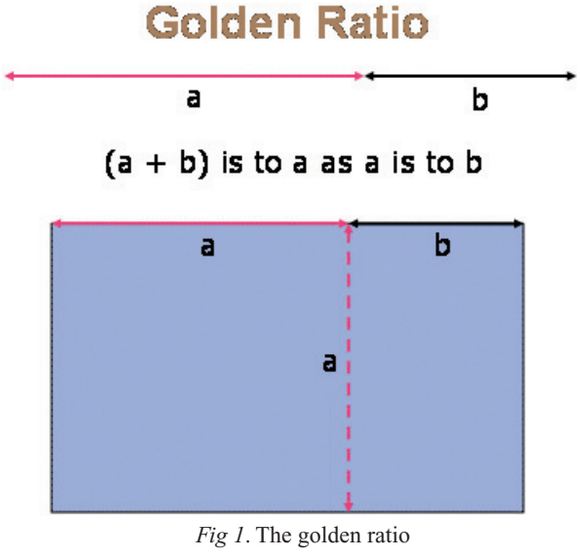

Fig 1. The golden ratio

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ratio in the average human body of the distance between the navel and the foot to the height and the ratio of the distance from the top of the head to the fingers to the height is the golden ratio, and again there are many others present. And we find these proportions in art for instance in the Sutherland tapestry of Christ in Glory in Coventry cathedral.

And not to leave out other specialities, for instance my respiratory colleagues - the divisions of the bronchi follow the rule and for our dental colleagues, the arrangement of the central incisors also. And the result of being perceived as beautiful is the person is thought more intelligent, more trustworthy, more likely to be employed and at better salary. These perceptions are important to us all but perhaps more so is the reverse perception of people with skin disease and the perception of those around them of the nature of skin disease. We are aware of the entries in the Bible, with its descriptions of what it called leprosy and the need to make others aware that you are unclean, you are dirty, and you are contagious. It has produced the leper complex for both the sufferer and the observer, still present today.

The descriptions given in the Bible covered many diseases other than leprosy, many of which were not contagious, such as psoriasis. However they were not too far off the mark with their anxiety and worry over so-called leprosy of clothes and buildings. My late colleague Dr Martin Beare showed that the fungus that causes cattle ringworm can survive in a sealed glass test tube for over a year and be successfully recultured. So also the fungus can survive on buildings, fencing and hedging, and continue to cause skin problems not only to host animals with a financial and user implication if the hide is seen as imperfect, but also to humans.

In all our dealings with patients with rashes there is constantly the "leper complex", and overlaid on that is the social importance of the skin. Look at the glossy magazines and the pages given to appearance. Appearance is everything. It is the first thing seen by others in social situations. The skin is one of the most important components of an individual's physical appearance. The skin on the face is under almost constant scrutiny in our daily interactions, though often unconsciously. If a person's form or colour is damaged then beauty maybe lost, and in modern society, individuals with an atypical facial appearance are often prejudiced against, and may experience severe social handicap, and the same applies to hand rashes.

Let me take psoriasis as an example of a chronic non-contagious dermatological disorder associated with cosmetically disfiguring skin lesions, often with severe social impact on the patient. The majority of patients feel they are stared at because of their psoriasis and regarded as contagious. They may experience outright rejection; asked to leave places such as a swimming pool, a gym or hairdresser. And because they anticipate rejection, they avoid these public places or interpersonal situations and thus reduce the quality of their life and social opportunities. It is always salutary to hear patients talking about their real problems, when they are talking casually together, then issues such as scaling in patients with psoriasis come to the forefront. The person who takes a vacuum cleaner on holiday, or the civil servant with a dustpan and brush in his briefcase to brush up around his chair before leaving work.

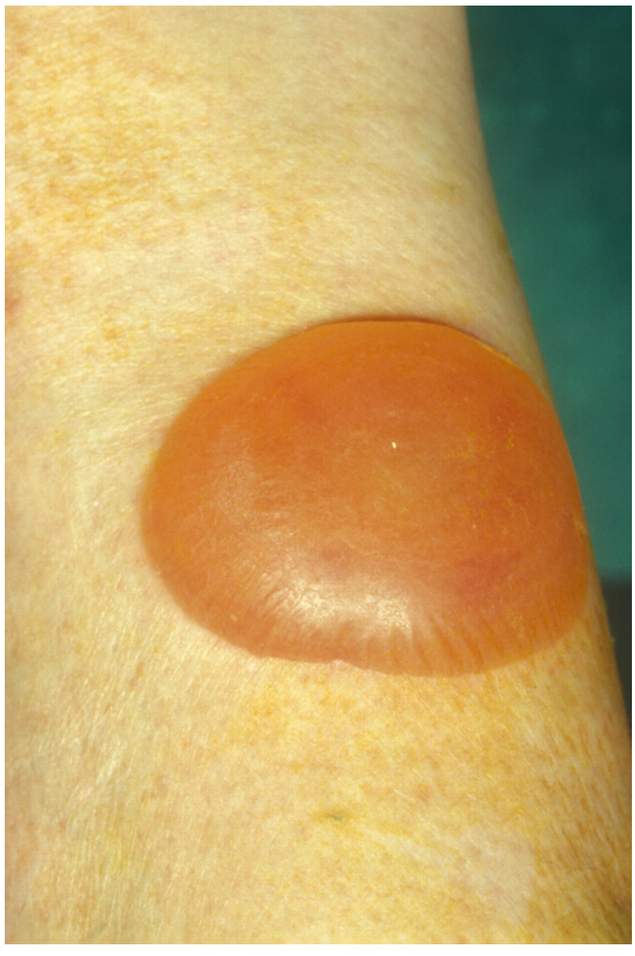

Fig 2. A blister,

The other skin condition particularly associated with social stigma is acne to which many of today's intended audience can relate, and which may lead to depression. The severity of acne can determine participation or rather lack of it in daily social activities, and adds to all the other pressures of adolescence. Individuals growing up in western society learn to believe that attributes such as clear skin, strong nails and clean hair are what are needed if one is to achieve that elusive quality of beauty. Therefore, if one lacks these features, because of a skin disorder then one is no longer seen as attractive or beautiful.

So from that how can I discuss skin disease as beautiful? So where is there beauty in skin disease. Might I suggest that it is there in colour, in form, and in pattern? I am not aiming to make you dermatologists, but let me suggest with a few slides that there is beauty in the appreciation as well as the physical appearance of some conditions. For instance colour. Like paint colour cards, a spectrum from pink to many shades of red, and yet all from the same condition, orangeybrown, or black. Or shape round with a ripple effect in tinea corporis, or with a target like appearance in erythema multiforme, or a non-anatomical patterned shape in dermatitis artefacta, a square, psoriasis in a donor graft site, or typical pattern of contact dermatitis from Elastoplast, or serpiginous from a larva of a worm. Do be wary of sitting on the sand on your next exotic holiday. I recently had a young patient who wasn't. And what about a blister? The intellectual reward of making a

Fig 3. Fungal culture plates

diagnosis purely from its appearance (fig 2). The thickness of the roof, the contents, the background, and also the mystery, why is there no surrounding inflammation? And what about the beauty of histology, staining for immunoglobulins in a blister, and routine histology surely beauty if only in colour, and metachromatic staining with purple of the mast cells using a blue dye**,** part of the fun of my intercalated degree. Enjoy the general picture of pathology, and then you will start recognising changes. Stay friends with your pathologist, who is still the last port of call for a tissue diagnosis, and as it seems a prerequisite of these lectures that Osler should have at least one quotation, then I would agree with his "As is your pathology, so is your practice". Clinical and pathological is the complete package. And while we are in the laboratory, what about fungal cultures (fig 3)? Surely there is a beauty in these? And what about the wee beasties; the flea and the adult head louse. Surely more than just their mothers love them. But as Confucius said ".. not everyone sees it". So there is beauty to be seen, the visual.

Secondly beauty and the intellect, beauty as knowledge. The more we know about a disease process the better we can manage it. For those considering research; advice I heard from Farrington Daniels junior, a photodermatologist and US government advisor in the 70's, that he gave his residents, was to read the standard textbook, find the most dogmatic statement and then look. It was often wrong. It has been written; "every fact of science was once damned. Every discovery was a nervous shock to some orthodoxy. We would own no more, know no more, and be no more if it were not for the rebellious, the recalcitrant, and the intransigent." Or Oscar Wilde put it more succinctly, "disobedience was man's original virtue" - my apologies to the chaplains.

So how has improved knowledge helped with psoriasis? How has it and how should it influence management? As we are nowhere near competing with those looking for the Higg's boson at CERN, the only comments I wish to make at the subcellular level is that the accepted wisdom that psoriasis was a condition of rapidly increased cell turnover of a few basal epidermal cells has changed to a normal rate turnover of increased numbers of cells, support for looking at accepted wisdom, and secondly that increased knowledge regarding inflammatory mediators, present in large quantities, has led to the introduction of a whole new class of therapeutic agents, the biologics. At the genetic level, although nine chromosomal loci have so far been described, even a major gene only determines 35-50% of the heritability, and that only in certain phenotypes.

We are however advancing enough to have a significant effect on therapy, where the emphasis has changed from one of reducing epidermal cell turnover, to dealing with the abnormalities of the inflammatory process. However for many years treatment has been anything but beautiful - creams and ointments. Imagine covering all your skin in an application, even just a moisturiser, at least twice per day. Then think if you had to apply a tar based product, the colour and the aroma, or one that stains; no wonder compliance was and is low. So you can imagine the joy of patients exposed to modern light treatment, slightly offset when they realised they still had to moisturise, and then the delayed findings of an increased risk of skin cancer. Systemic drugs were also much appreciated as generally easy to take, but still moisturisers were needed and there were side effects, the liver, kidneys, immunosuppression and fetal abnormalities.

And now the biological drugs. But of course there is a downside such as re-activation of TB and increased rates of infection. When they work it seems miraculous to the patient, as they add a further weapon to our therapeutic armamentarium, but they do cost, though the NHS Economic Evaluation Database has accepted a German paper[1] showing an economic advantage of etanercept, a biologic, over conventional therapy for certain groups of patients. So for each treatment there is a balance of gains and loss.

Therefore can we make topical agents easier to use, retain their apparent better safety profile, and at low cost? A major direction at present seems to be in the field of nanotechnology. A nanometer one billionth of a metre; the ratio of a marble to the earth; the length a hair in the beard grows in the time it takes to lift a razor to the face. I suspect that if you remember nothing else from this lecture you will about beard growth.

As so often it is the cosmetic companies, who are leading the research especially with sunscreens, and of course everyone who has to apply topical agents wants cosmetically acceptable ones. But there seems a long way to go. We do not know how many chemicals act when at the nano size. One cannot simply transpose the behaviour of large molecules, with which we are familiar. I am also very wary of technology in which military agencies are interested. If we are concerned by the spread of CCTV then think if a nanoparticle could be applied to you, without your knowledge, giving a constant readout of where and what you were about. As usual the balanced debate is being led by the newspapers. For instance, "if your suntan lotion can change the sex of fish, what can it do to you?", "The stuff is not only on your skin - it's in your tap water and lunches, too". "They can penetrate the brain", but companies are saying that the zinc oxide nanoparticles are fixed in the lotions, and are inert, while others suggest that none are inert at this size. So there is still a way to go.

There remain many holes in our knowledge. We have no explanation for distribution - psoriatic plaques are normally over the knees and elbows; but then why is guttate psoriasis predominantly on the trunk? Again little is known about the natural history, predictors of disease severity or remission. There are no biomarkers estimating activity. And if cleared by treatment, is it really clear? There remain many mysteries.

I am sure we all expect new knowledge at the subcellular level, but there is much new knowledge available at the patient and

societal level, which is probably more important to the patient, and this reflects a theme that is common to many specialities who deal with chronic inflammatory disease. Many years ago the late Professor Pantridge asked me how and why did patients with psoriasis die. I did not have an answer, but in my defence they so rarely died under our direct care that we had no idea of the causes of death. Now a major advance is the increasing realisation of comorbidities, associated with chronically increased levels of pro-inflammatory mediators as seen in psoriasis[2].

Psoriasis is associated with metabolic syndrome (obesity, impaired glucose tolerance, abnormal levels of fat in the circulation, arterial hypertension and is twice as common in forty to sixty year-old patients with psoriasis as among healthy people. In addition significant coronary plaques are twice as common in patients with psoriasis compared to controls and a thirty year-old patient with moderate to severe psoriasis has a threefold increased risk of myocardial infarction with mortality due to myocardial infarction or stroke two and a half times higher in patients characterised by early or frequent hospitalisation. Psoriasis is not just a skin disease or joint disease after all. The other major improvement in knowledge is the ability to measure the burden, especially psychological, both for patients and for their helpers and give them numbers that are robust and reproducible. Better than the simple " how are you feeling". The SF36 short form, with its 36 questions, is used to compare the impact of different diseases. The lower the score the bigger the impact. Psoriasis with diabetes and worse than cancer[3]. There are specific survey forms for psoriasis, the PASI - a physician determined score based on erythema, or redness, degree of scaling, induration and area of skin surface involved, and Quality of Life issues such as the dermatology life quality index[4], a patient determined index, consisting of 10 questions related to symptoms and feelings, daily activities, leisure, work and school, personal relationships and trouble with psoriasis treatment. Both score from 0 - 30, with lower scores corresponding to a better quality of life. Moderate to severe disease is with a PASI >10 either alone or with a DLQI >10.

HOW DO SCORES TRANSLATE TO MANAGEMENT?

In over 1500 patients attending dermatologists[5], there was a mean PASI of 12.0 with mean disease duration of 17.6 years. Over a quarter had been hospitalised; virtually all had had topical therapy and two-thirds had UV-phototherapy, but only one third systemic therapy. There was a severe sub-group of ~20% of patients with a PASI > 20, in whom 12 workdays had been lost in the previous 12 months per patient. Virtually one fifth were unable to work (mean = 133 days), half had been hospitalised in the last 5 years, almost 60% had a DLQI > 10 and yet less than 50% had had systemic therapy. That does not seem to read very well.

But it is not just the patient who is affected. In another study[6] looking at the effect on others in the household, there were 63 subjects questioned of whom 28 were relatives and 35 partners. The Patients themselves had a mean DLQI of 10, and mean PASI 5.2, and 40 aspects of quality of life were identified in 6 categories. The results showed that 70% complained of extra time on housework, laundry and vacuuming, 57% of psychological pressures (mainly anxiety and worries about the future), 55% of social disruption (such as meeting people), 44% of holiday plans (including sport and leisure), 37% of daily activities, shopping, work and dealing with other members of family, and the same figure for effects on personal relationships.

The subjects' Quality of Life was related to the patients Quality of Life and not disease severity scores. There certainly appears to be room for improvement, but I wonder how figures would look in other specialities.

WASHING AND SUNTANS

Having said at the beginning that I was not going to discuss Botox etc. I am going to discuss two activities that related to beauty have had a singular effect on dermatology services in recent times.

The first of these is washing and the associated beauty/ cosmetic business and the use of water. In 1961 water used per head for bathing was 11 l/day, rising to 51 litres in 1997. For 2008 around 80 litres per day is necessary. This is out of a total daily usage in England of 145-150 litres per person, per day. UK sales of bubble baths have risen from £76 million in 1981 to £173 million in 2001. Total UK sales in 2006 were £4 billion for personal wash products. With all the skin washing we are seeing an increase in the amount of dry skin and eczema, especially in the vulnerable skin of the young and the old, who then need to apply moisturisers. There are so many complaints of reactions to topicals that manufacturers seem to list more of what is not present than is.

The second major activity, that was pre-eminent in the last century as an aid to beauty, was that of acquiring a suntan. People went on holiday to get a tan, and if you came back pale it had been a failure; and what has been the result? Let us look at the pin-up girl to a certain generation - Brigitte Bardot. If one compares pictures of her in her prime in the late 1960's to those, even in the early 1990's, one can see enormous changes in terms of wrinkling and elasticity, showing the effects principally of the sun. If symmetry and balance are beauty look how easy it is to destabilise just by attaining a tan.

If aging changes are not enough to frighten you, what about the development of skin cancer? There is a problem when we come to look at the figures. Nationally, if figures are collected at all for non-melanoma skin cancer, then only the first episode is recorded and the Northern Ireland Cancer Registry has followed this practice. A registry audit suggested that 50% more skin cancers are removed than patients registered. We do have patients who have had up to 50 and more primary basal cell carcinomas removed. Using the 2007 pathology figures for the Belfast trust, which included some material from the Ulster hospital, then of 52,000 biopsies reported that year approximately a third of all, just under 14,000, were for skin lesions of which 2097 were for basal cell carcinoma, and 489 for squamous cell carcinoma.

Unless you have been living totally in your own world, then you must be aware of the issues surrounding malignant melanoma; the increases that have occurred in the latter part of last century. In a recent paper[7], between 1984 and 2005 in the province there has been a 288% overall increase, with males at 340% and females 260% but again this does not reflect the true work implications. Virtually every MM has two surgical procedures the first being to excise the lesion, which

allows histological staging, and a wider second excision. In addition the best centres in the UK would suggest that around 20-25 moles are removed for every malignant melanoma, and there are no figures available for the number of pigmented lesions that are referred, that do not require biopsy or surgery.

In 2007 there were 291 malignant melanomas reported in the Belfast trust (Dr Maureen Walsh, personal communication) with a further 1797 benign naevi, which at a figure of 8 to 1 benign to malignant gives us a much better figure than elsewhere, but raises a question are we not removing enough? And that does not include other pigmented lesions. Our figures suggest that we see three patients for every one who has a procedure. For the trust that means about 5,400 cases a year have to be red flagged, that is seen within two weeks of referral for query malignant melanoma, or changing mole, and does not include other red flag items. If all this work is the result of recent efforts to achieve a desired appearance what does the future hold for my successors from some of the present techniques that the public willingly undergoes seeking beauty, and delaying aging?

Having mentioned the beauty that lies in symmetry and balance, we can see this even when we look at skin cancer. A basal cell carcinoma relatively banal, in this type is balanced and symmetrical. Benign moles again are symmetrical and balanced, but when malignant, asymmetrical and unbalanced. There is no beauty. This is the price of achieving beauty.

It has had a distorting effect on our work balance of skin cancers and pre-cancers vs. rashes, new and review. A recent Edinburgh study[8] reported that 46% of their new referrals were for tumours, benign and malignant and 24% for psoriasis and eczema, but only 20% of reviews were for cancer with 40% for the big three rashes, eczema, psoriasis and acne. Their new referral rate has risen by 67% between 1980 and 2005, from 12.6 per 1000 population to 21. And interestingly over the same period internal referrals had almost quadrupled to 11% of total in 2005.

Andrew Finlay[9], in the 2000 Dowling Oration, (the big annual set piece of British Dermatology), made a particular plea for medical dermatology, which he saw being threatened politically by the emphasis on seeing skin "lumps and bumps". He asked the question "Are we meeting patient's needs?" I have already largely answered that question. I have discussed the shortfall in medical management and patient desires for clean and easy to use treatments. Skin tumours are usually simply cured by surgical techniques, but this is not the same for the chronic inflammatory skin conditions. We do not have cures, treatments are messy, compliance is poor, 36% of parents of children with atopic eczema admit to non-compliance. Knowledge and education outside secondary care is inadequate. Research has shown that the disability suffered by those seen in primary care and not referred on was just as marked as those sent to secondary care, and in a Welsh study[10] looking at Quality of Life scores after attendance at a dermatology clinic, the greatest benefit was perceived by those with psoriasis, eczema and acne ahead of those with cancer. There is a great untapped need. This suggests that patients with severe inflammatory skin disease deserve priority in the organisation of skin clinics, which seems to have been lost in the drive to deal with skin malignancies.

I was therefore delighted to read the consultation document from the board of the Belfast Trust entitled 'New Directions', with its particular emphasis on patient choice. Ours will be very expectant, and also the need for centres of excellence to provide the knowledge, skills and critical mass to provide these desired treatments. A chronic inflammation diseases emporium to match the cancer centre. One can but dream.

This lecture by tradition has been directed at the new clinical medical students, so if mathematicians, engineers, architects strive for beauty as the right solution to a problem, then even more that should be your aspiration as you draw a picture of medical care that you give and it does not matter what the condition is, nor what speciality you are in. However one of your biggest challenges will be to draw the same standard of picture for everyone you deal with. You will be challenged by the so-called heart sink patient, the alcoholic, the drug addict, and the prisoner. It is a real challenge to provide the same service to a prisoner who has killed, as it is to the widow. A recent anonymous personal view column in the BMJ said "we all meet patients who make our hearts sink. We will all meet patients who challenge our personal values and beliefs. We will all meet patients who will fill us with a sense of disapproval". How will you treat them? At the same time do not be seduced to provide a better service for those who might be perceived as important. Do not cut corners "being nice" when caring for colleagues.

But if you are to be enabled to produce the best picture of care there are two major parts of the picture missing from what I have already discussed, and to an extent outside your control and that is your medical education, which has been such an important tradition of this hospital, from its inception, and secondly the politico- managerial influences on health care. When I left the academic staff of this medical school we had amongst the worst staff - student ratios of the old medical schools in the UK. Since then the student numbers have risen from 864 in 2000 to 1160 in 2007, whilst there has been minimal change in the numbers of clinical academic teaching staff. The result is large numbers of students going through many clinical attachments, each in a very short time, often only for one week and this at the same time as the pressures are on medical staff to increase patient throughput. For you in your clinical studies it is even more important then, that you remember that you are in a process of adult learning, not passive teaching. There is the well known aphorism "see one, do one, teach one"

But that had been anticipated by Confucius (you can see how I reckon the balance of political and economic power is going to develop) who said "I hear and I forget. I see and I remember. I do and I understand."

Keep looking; do not be happy with ticking the box; I have seen my case of whatever in this attachment. It is repetitive seeing that leads to remembering and if you get the chance then do and doing includes proper examination. Corrigan, of his pulse, the 19th century Dublin physician, said "The trouble with doctors is not that they don't know enough, but that they don't see enough". Changes in junior doctors training due to European Working Time Directive and in the programmes themselves, have the trainees themselves complaining about lack of exposure.

So how do these parts, education and management, look in the picture that is medical care? It was earlier this year sitting in a dive boat looking across a bay at all the yachts at anchor that I saw the answer. I was conscious of two styles of design. The first was an older design, of flowing lines, above and below water. It was well finished; there were cabins for the crew. The sail area was such that most of the time even when racing it was only at 95% of its performance and safety limits, so it did have a slight degree of slack to meet an emergency, that inevitably happens at sea. The other style is that of the modern extreme racing machine. It is absolutely stripped out, bunks for only half the crew, on a Cox and Box principle, no doors for privacy and the crew living in their oilskins. Underwater the keel and rudder are hung from narrow supports. It is driven at 100% or slightly over the safety margins of the rigging and sails, and with a minimal number of crew. The problem is there is no reserve and when parts break, or there is an injury, then at great expense parts or a temporary crewman is helicoptered in, things put right, and helicoptered out but only to leave the boat in the pre-existing state.

So how is education and management being painted in? Over the years the sections have been frequently overpainted. At present it looks like the extreme model. I am reminded of the law propounded by Patrick Hutber, city editor of the Sunday Telegraph which states "improvement means deterioration". So for all involved in health care, and not just those in the medical profession, for everyone who works in or has influence in an institution such as this and that includes the porters, the administrators and even the politicians, as well as the doctors, nurses and allied professions there should be the same end picture.

We are all aware of how we react to our surroundings, our environment, our treatment on holiday, the lift we get or depression. If that is how we feel when well how much more important it is when ill. But whatever is present in the outer parts of the picture, and making up the background, in the centre is a patient and not just a client. Isn't it interesting how these less personal terms seem to slip in? But who is that patient? Is he a case or a real person? He has experiences, he has worries. So who is that patient? We were always taught to practice with the same care as you would wish if that patient was your parent, your sibling, your child, not just a bed, not just the twentieth psoriasis of the afternoon.

There are those here, who are under intense pressure to produce good-looking figures, for waiting lists, for throughputs, whatever their constituency, but to you can I also ask that you too consider the service provided. It is to an individual, a member of your family, your partner, your child, your parent. I pray that there is not a need to remember John Donne[11] who said "I observe the physician with the same diligence as the disease." He obviously in the 17th century had a different agenda, but we do have patients asking if decisions are finance or time based. To all who deliver care, and to all who plan, give time to the patients. That great philosopher Winnie the Pooh had the right approach when he said "Sometimes I sits and thinks and sometimes I just sits". It is remarkable what solutions can be found, decisions made, and more importantly, ill considered decisions avoided.

I started with Confucius, but let me finish with two others coming from different directions. The first is John Wesley, whose rule includes "do all the good you can, in all the ways you can, to all the people you can" and secondly one of the greatest thinkers of the last century Einstein. And though what he said was not to a medical audience it still applies: "The most beautiful thing we can experience is the mysterious. It is the source of all true art and all science". (Note he says both all true art and all science. Not one or the other). And he continues "He to whom this emotion is a stranger, who can no longer pause to wonder and stand rapt in awe, is as good as dead: his eyes are closed"

Put those words of Wesley and Einstein together and it is not a bad way to practise medicine and the picture you paint will bring pleasure to the eye, to the intellect and to the moral sense.

That is Beauty.

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